SUMMIT MEDICAL GROUP
Health Information Questionnaire

Today's Date: _____ **Which doctor are you seeing today?** _____
Patient's Name: _____ **Date of Birth:** _____
Pharmacy Name: _____ **Telephone Number:** _____
What medications are you currently taking?

Medication:	Prescribed by:	Do you need a refill today?

Are you allergic to any medications? _____ If yes, what medication? _____
What type of reaction did you have to this medication? _____
Are you currently pregnant or nursing? _____

What is the reason for your visit today? _____

Please check any symptoms below that you are currently experiencing:

♦ **General**
___ Recent Weight gain/loss?
Amount _____
___ Fatigue/Lack of energy
___ Fever/Night sweats

♦ **Ears/Eyes/Nose**
___ Ringing in ears or hearing loss
___ Loss of vision
___ Double or blurred vision
___ Sinus drainage or congestion

♦ **Mouth/Throat**
___ Sores in mouth
___ Hoarseness
___ Difficulty or painful swallowing
___ Swollen glands

♦ **Breasts**
___ Pain
___ Lump
___ Discharge from Nipple

♦ **Heart and Lungs**
___ Pain in chest
___ Irregular/Fluttering heart beat
___ Shortness of breath
___ Short of breath when lying flat
___ Swollen legs/feet
___ Cough
___ Coughing of Blood
___ Wheezing

♦ **Stomach/Intestines**
___ Frequent heartburn
___ Nausea
___ Vomiting of Blood
___ Constipation
___ Persistent Diarrhea
___ Red blood in stools
___ Black or tarry stools

♦ **Kidneys/Bladder**
___ Painful urination
___ Discharge from penis/vagina
___ Blood in Urine
___ Getting up at night to urinate
How many times?_____

♦ **Skin**
___ Rash
___ Sores/Moles that won't heal
___ Dark or enlarging moles

♦ **Muscles/Joints/Bones**
___ Morning stiffness
Minutes_____
Hours_____
___ Joint pain or swelling
Where? _____
___ Muscle weakness/Tenderness

♦ **Nervous System**
___ Frequent headaches
___ Sensitivity to pain in hands or feet
___ Memory loss
___ Difficulty walking or with balance/coordination

♦ **Endocrine**
___ Heat or cold intolerance
___ Excessive thirst/urination
___ Periods regular
Yes_____ No_____
Last Menstrual Period:_____
Age when periods stopped_____
Last Pap: _____
Contraception: _____

♦ **Habits**
Do you use tobacco products?
Yes _____ No _____ Past ____
Cigarettes per day _____
How many years have or did you use tobacco? _____
Drink more than 2 alcoholic beverages per day?
Yes_____ No_____
Cups of coffee per day? _____
Use seatbelt regularly?
Yes _____ No _____
Do you use drugs for reasons that are not medical? If so, please list:
_____
_____

(See additional questions on back of form.)

Past History:
Have you been treated for any of the following conditions in the past? If so, please list approximate dates of treatment and treating physician.

Condition:	Approximate Dates of Treatment:	Treating Physician:
Psychological:		
Diabetes		
GI Disease		
Liver Disease		
Heart Disease		
Phlebitis		
Anemia		
Arthritis		
Blood Disease		
Thyroid Disease		
Weight		
Cholesterol		
Seizures		
High blood pressure		
Stroke		
Genital/Urinary Disease		
Serious Accident:		
Surgeries:		
Hospitalizations:		

Marital Status: _____ **Number of Children:** _____

Family History:
Have any members of your immediate family (parents, siblings, grandparents, children) ever had:

Breast Cancer? _____ **If so, whom?** _____
Colon Cancer? _____ **If so, whom?** _____
Other types of cancer? _____ **If so, whom?** _____
High blood pressure? _____ **If so, whom?** _____
Stroke? _____ **If so, whom?** _____
Heart problems? _____ **If so, whom?** _____
Diabetes? _____ **If so, whom?** _____

Please list any other relevant information or questions you may have for the physician today:

_____

_____

_____